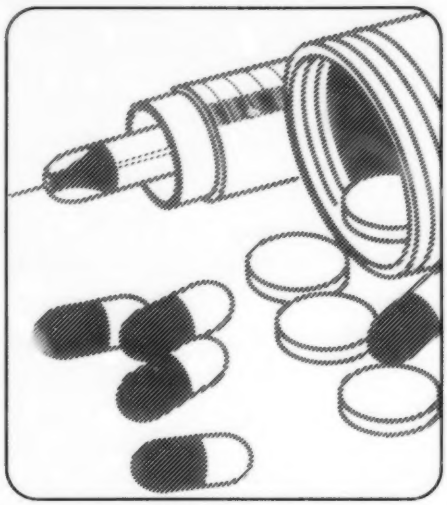
Canadian Centre for Occupational Health and Safety

Centre canadien d'hygiène et de sécurité au travail



SUBSTANCE ABUSE IN THE WORKPLACE

A Workshop

P92-2E

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SUBSTANCE ABUSE IN THE WORKPLACE

A WORKSHOP

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This proceedings of the Substance Abuse in the Workplace Workshop, April 11 and 12, 1991, in Hamilton, includes the presentations of panelists, discussions, and reports of work groups. It has been edited for publication in consultation with panelists and work group leaders.

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Canadian Centre for Occupational Health and Safety

SUBSTANCE ABUSE IN THE WORKPLACE

A Workshop

Thursday, April 11 and Friday, April 12, 1991
Holiday Inn Hamilton, Hamilton, Ontario

Thursday, April 11, 1991

8:15 am — REGISTRATION AND COFFEE

9:00 am — **Welcome and Introduction to the Workshop**
Lillian Vine, Manager, Workshops and Conferences
Canadian Centre for Occupational Health & Safety

9:15 am — **Presentations**

A Social Perspective
Jan Skirrow, Chief Executive Officer
The Canadian Centre on Substance Abuse

A Labour Perspective
Nancy Riche, Executive Vice-President
Canadian Labour Congress

A Company Develops Policy
Ken Smith, Project Leader, Alcohol and Drug Policy Development, Imperial Oil Limited

A Business Perspective
Sanderson Layng, President
Alliance for a Drug-Free Canada

A Workplace Health Professional's Perspective
Ian Arnold, President, Occupational Medical Association of Canada

Treatment
Garth Martin, Acting Associate Director
Clinical Institute, Addiction Research Foundation

Legal Aspects of EAPs
Robert Solomon, Professor, Faculty of Law
University of Western Ontario

Open Discussion

Canadian Centre on Substance Abuse

CCSA - CCLAT

LUNCH

Workshop #1 - Definition

a) Is there a problem in the workplace?
b) How do you define the problem in terms of worker safety, public safety, cost, productivity, health issues?
c) Is the problem caused by use or abuse of: alcohol, over-the-counter and prescription drugs, illicit drugs?

Workshop #2 - Prevention

a) What are the conditions that can lead to the problem?
b) How can we prevent it?
c) Whose responsibility is it? Who has the control?

Workshop #3 - Alcohol and Drug Testing

a) Why would we test? Would it lead to prevention?
b) Can it lead to discrimination? To assistance or to discipline?
c) How do you protect privacy and confidentiality?
d) How do you establish policy?

6:00 pm DINNER

Friday, April 12, 1991

8:30 am COFFEE

9:00 am **Workshop #4 - Treatment**

a) What are treatment options: self-help groups, peer prevention/referral, employeee assistance programs, institutional care?
b) What kind of support is needed?
c) How do you follow up?

Workshop #5 - Homogeneous Groups
Consideration of options/solutions
Preparation of report

COFFEE BREAK

Plenary Session
Reports of Homogeneous Groups
Conclusions

1 pm **Close of Workshop**

EXECUTIVE SUMMARY

Is substance abuse a problem in Canadian workplaces? If so, does it merit legislation, regulation or company policies? Should these include workplace drug testing? The answers are not straightforward; much depends on perceptions; and the questions are heavy with controversy.

To explore and clarify the issues, the Canadian Centre for Occupational Health and Safety and the Canadian Centre on Substance Abuse jointly organized a workshop on "Substance Abuse in the Workplace" in Hamilton on April 11 and 12, 1991. Participants came from labour, management, governments, and professional organizations.

Presentations were given by Jan Skirrow of the Canadian Centre on Substance Abuse, Nancy Riche of the Canadian Labour Congress, Ken Smith of Imperial Oil Limited, Sanderson Layng of the Alliance for a Drug-Free Canada, Ian Arnold of the Occupational Medical Association of Canada, Garth Martin of the Addiction Research Foundation, and Robert Solomon of the Faculty of Law, University of Western Ontario.

Jan Skirrow said human beings have always taken drugs and always will. Which is why the US war on drugs and the campaign to create "drug free" workplaces lack realism. We need a long-term strategy for all substances that do harm.

Nancy Riche spoke for labour in not wanting American solutions to American problems. Labour believes in treating the cause, not the symptom. And Riche pointed out that the degree of drug use is significantly lower than that of alcohol use.

Ken Smith described his company's development of a policy to replace one that was fragmented and incomplete. He described substance abuse as an emotional, complex issue which probes the boundary between personal and work life.

The Alliance for a Drug-Free Canada of which Sanderson Layng is president is interested in substance abuse for straight economic reasons. It is not satisfied to describe the problem; it wants to solve it.

"Abuse is a health issue," said Dr Ian Arnold. And the role of the occupational health professional is to assist workers, to educate, to prevent, not to write policy. Nor, he felt, does the occupational health professional have a role in testing employees.

Speaking on treatment, Garth Martin emphasized the importance of early intervention, of feedback, and a de-emphasis on residential treatment. He said patients with stable backgrounds have the best chance of recovery.

Robert Solomon was particularly explicit in urging a Canadian perspective deploring what he termed the "Miami Vice" view of drugs with its violence and emphasis on illicit drug dealing. It is essential to identify the greatest causes of the greatest harm, he said, and to keep drug abuse in perspective and not let its sensationalism overshadow more serious problems. He lucidly explained confidentiality/privileged information.

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In the work groups, participants discussed definition, prevention, alcohol and drug testing, and treatment. They found it difficult to define the "problem" and they agreed that although substance abuse is not an epidemic in Canadian workplaces, it would be naive to believe it does not exist at all. They found it impossible to totally separate work life and private life and urged that chronic use and occasional use be looked at differently. They discussed the importance of not making moral judgment but looking at safety as the goal. Personal liberty and public safety have to be weighed. They discussed stress at work and at home, job culture, job design, peer pressure, lack of control as some of the possible causes of substance abuse. Nor can gender issues or cultural factors be ignored. They saw drug testing as a last resort. They emphasized the importance of involvement and ownership in any program. In treatment, they looked at health care costs and the recent revelations that people were being sent to the US for rehabilitation at great cost to the health care system, the same system which may not cover the costs of the most effective counselling.

INTRODUCTION

Lillian Vine

Ladies and gentlemen, welcome. I am very pleased that you are here with us; I think we are going to have a very exciting workshop. I am Lillian Vine, Manager of Workshops and Conferences for the Canadian Centre for Occupational Health and Safety. About a year ago, we had a workshop in Halifax and on the way back I met in Ottawa with Jan Skirrow of the Canadian Centre on Substance Abuse. We had a brief meeting where we explored the idea of collaborating on this workshop on Substance Abuse in the Workplace. We both though it an excellent joint opportunity and it has been. One of the things that we could not predict was that the country would be in the throes of a recession and that has hurt the attendance. The numbers are small but the quality is very high and I think that we are going to have excellent discussions.

I would like to call on the Chairman of the Council of Governors of the Canadian Centre for Occupational Health and Safety, Maureen Shaw, to welcome you.

Maureen Shaw

Good morning. I welcome you on behalf of myself and the Council of Governors and all the stakeholder groups that we represent. I don't worry about the numbers being low because usually that means there will be some very good discussion and some good ideas and a good flow of information back and forth. One of the things that I strongly support is the work that Lillian and her staff do at the Centre in the area of seminars and information sessions. It is a very important area. As you know, our mandate is the gathering, interpretation and delivery of information and there is no better way of delivering and gathering information for our use than through this kind of information exchange. I wish you good discussion and good exchange of information.

Lillian Vine

We try very hard to ensure that the component areas of a topic are well considered in our workshop agendas. For each seminar or workshop I put together a planning committee--all are very good, this one was exceptional. Some members of that committee are with us. On the committee were Ian Arnold of the Occupational Medical Association of Canada; Linda Wilcott of

the Canadian Labour Congress; Mike DeGagné of the Canadian Centre on Substance Abuse; Bruce Cunningham of the Addiction Research Foundation; Barbara Butler, a consultant working with Imperial Oil; Eugene Oscapella of the Privacy Commission of Canada; Enid Donaldson, Suzanne Arnold and Judy Pope of the Occupational Health Nurses Association; and Judith Bellis of the Ontario Law Reform Commission. We worked well together; I think we can be pleased with the agenda that resulted from our cooperative efforts.

There are two objectives to this workshop; one is to present to you not only technical information, but also various perspectives and areas of this difficult topic; we have a roster of speakers which is second to none. The other is to facilitate your exchange of experiences, of thoughts, and your discussion; we do this in small groups. We have had people tell us that the discussions in these groups have changed their minds--you know how unusual that is. People have also told us how surprised they have been to find so much agreement among people who had never met, who came from varied backgrounds, who had often been in adversarial positions. It is an exciting process and I get high on it and on the enthusiasm of the many people who contribute to its success. The people on the planning committees and the speakers travel at their own expense and give their time to us. Our group leaders are participants who register for the workshop and who then give us their time. It is very humbling and we are truly grateful.

A SOCIAL PERSPECTIVE

Lillian Vine

Our first speaker, to talk about a social perspective, is Jan Skirrow, the Chief Executive Officer of the Canadian Centre on Substance Abuse. Jan's experience in substance abuse education goes back throughout almost all his career with the Alberta Alcohol and Drug Abuse Commission--as a manager of Community Extension Services, an education consultant, a Director of Program Development Division, and as Chief Executive Officer. He took a brief break to be a Deputy Minister in the Department of Community and Occupational Health in Alberta and a Vice-President of Corporate Services at the University Hospital in Vancouver, before becoming the Chief Executive Officer of the Canadian Centre on Substance Abuse in Ottawa.

He holds a Bachelor of Applied Science degree from the University of British Columbia and a Master of Science degree from the University of Calgary. He has been a member of various federal/provincial conferences, advisory committees, working groups and tasks forces; Chairman in 1985 of the 34th International Centenary Congress on Alcohol and Other Drug Dependencies sponsored by the International Council on Alcohol and Addictions, in Lausanne, Switzerland; Vice-President (Hon) in 1985-1988 of the International Council on Alcohol and Addictions, Lausanne, Switzerland; an expert consultant for the Canadian Substance Abuse Centre in Ottawa; and an assistant professor at the University of Toronto, Faculty of Medicine, Department of Health Administration, which he holds presently.

The titles of his recent publications and presentations cover three pages. Jan, I am delighted you are with us.

Jan Skirrow

It was a pleasure for the Canadian Centre on Substance Abuse to be able to work with the Canadian Centre for Occupational Health and Safety to organize this workshop. On behalf of our Centre, its Board of Directors, and its staff, I welcome you here. Our hope is that your thinking about workplace drug problems will be challenged and expanded by this session.

My Centre exists to stimulate discussion of substance abuse issues. I want to encourage you to move beyond a focus on drug testing or a concern just with specific drugs to the broader issues that are involved in this field.

The Canadian Centre on Substance Abuse came about as a result of a process that began in late 1986. Federal authorities held consultations across Canada with many organizations concerned in some way with substance abuse issues. This effort reflected a growing concern with the sharp rise in cocaine use.

The initial focus was solely on illicit drugs. But the people conducting the consultations soon came to realize that our old favourites like alcohol, tobacco, and medications were wreaking far greater havoc on the health of Canadians than were illicit drugs.

The result was a long-term strategy that addressed all substances that create harm in their users. The National Drug Strategy, later renamed Canada's Drug Strategy, was announced in Parliament on May 25, 1987.

The strategy provides a framework to bring together the many agencies concerned with the problems of drug abuse. But this framework needed a national focus, preferably outside of government.

As a result, the CCSA was formed by an Act of Parliament in 1988. We are a small, arms-length, semi-autonomous corporate entity, operating as a national agency.

The "war on drugs," as it has been called, gave birth to our Centre. We are committed to reducing drug abuse but we do have our own ideas on how this might be done. I was reminiscing a few days ago with a colleague who got involved in this business about the same time I did--in the mid-60s. We already knew a great deal about the abuse of alcohol and drugs and thought that through incremental change over time we could lick these problems. It hasn't worked out quite that way. Let's gain some perspective on the issue.

In 1885, the Victoria, BC, Chief of Police announced that "Opium is the Chinese evil...used in every house without an exception. This evil is growing with the whites...I have seen white women smoking in the Chinese dens myself." This theme of opium as a degrader of white women by Chinese men was used as a starting point by many West Coast organizations, including organized labour, to mount a virulent campaign over the next several decades to stop Chinese immigration and to deport those who were already here. Even Canadian citizens of Chinese origin, including one 23-year resident of Calgary--a grandfather--were stripped of their citizenship and deported because of opium possession. Even World War II didn't stop this process, although I am curious as to how it was managed.

In 1911 the Opium and Drug Act outlawed a drug called eucaine. No one knows how it came to be included, but Mackenzie King assured the House that it was deadly. In 1930, the government decided it was harmless, yet it remained in the Act until 1961.

In 1929, a special drug prosecutor in Winnipeg urged federal authorities to revise the Opium and Narcotic Drug Act so that anyone who received a package of drugs in the mail would have to prove that they were sent without his or her knowledge or consent. This was rejected by the Ottawa bureaucrats, not because they disagreed with it, but because they thought that Parliament might object to it, and at the same time toss out other more important amendments. It wasn't that they feared rejection because the proposal removed one of our most fundamental protections. They were concerned that it might occur to Parliament just how vulnerable innocent people would be to blackmail. In fact, the notion of guilty until proven innocent was enshrined in the 1911 Opium and Drug Act for other drug offences. It remained until the recent Canadian Charter effectively removed it.

In the 1970s, President Nixon, in an innovative attempt to stop the use of marijuana, had crops in Mexico sprayed with paraquat, a dangerous herbicide. The growers simply harvested the dying, herbicide-laden plants, and sold them to unsuspecting users. The major effect of that effort was to create a thriving indoor marijuana industry in the United States. Within the last year or so, efforts to detect these cottage industries using airborne infrared sensors and through the monitoring of power consumption of private homes, have been foiled by growers who have created underground facilities worthy of Saddam Hussein. With a concrete roof so thick as to effectively foil airborne detection, and self-contained electrical generating plants, these ultramodern industrial enterprises continue to grow and market a product obviously much in demand at great profit.

Of course, all of this has led to the eradication of drug use in our society; hasn't it?

The War on Drugs has been a favourite activity of American Presidents, law enforcement organizations, government bureaucrats, and just about every other group and organization in our society for well over a century. After all, who could be against eliminating drug use?

Now, we are told that worksite urine testing is necessary to eradicate drug use or at least to protect the public. We are told that the success that such a measure will bring more than justifies the accompanying assault on individual rights and freedoms, not to mention the simple human dignity of those tested. By the way, these will include pregnant women and middle-aged grandpeople, as well as young men with mohawks and earrings.

I must urge you to carefully consider what we have tried, for the best of reasons, over the past century in this country to eliminate drug use. I urge you to be extremely skeptical.

I must urge you to carefully consider what can realistically be accomplished and whether our proposed strategies are likely to make the situation better or worse. Surely, it's about time we started to get it right!

In the late 1960s, Ken Low, President of the Action Studies Institute of Calgary, made a sharp departure from the notion that innocent people were inevitably corrupted and degraded through the power of a drug taken for kicks. He said that most people use psychoactive drugs as a legitimate, if sometimes dangerous means of managing the way they feel and how they interact with their environment. Whether individuals have developed the basic skills and abilities essential

to a constructive life will have a great deal to do with whether or not they will use drugs; their pattern of use; and how they will respond to problems that may develop.

Consider this notion. It is not accepted by most policy-makers. However, the scientific evidence supports it far more than it does the alternate concept that underlies most of our public drug policy.

I would like to propose a few basic working assumptions that flow from this idea. They may help put drug problems into a context. At the least, they should provoke animated discussion for the duration of this symposium.

- Human beings are drug-seeking creatures--almost every society known to history has had drugs and drug problems. The few that did not, used physical stress to achieve the same effect.

- Addiction problems exist as part of the human condition. There will always be drugs and people who harm themselves by using them.

- Drugs come and go. Today's popular drug will be unpopular tomorrow. LSD use exploded for a few years and then settled down to the low level use found today. It has major drawbacks as a recreational drug. Normal people aren't stupid; they rarely persist with LSD. Cocaine use is declining; it also isn't the treasure many think it is when they start. Education can speed this process.

- Above all else, preventers should first do no additional harm as they pursue the welfare of the individual and society. Deporting Chinese opium smokers dramatically reduced such use and led directly to the spread of heroin, which was easier to import, much harder to detect and far more deadly.

- We can't easily impose standards of behaviour. Each of us resists--to varying degrees--this imposition. This is not a result of drug effects; this is what it is to be a human being. Our own experience and values and those of our friends are more important than what the government says.

- Be extremely skeptical of bureaucrats and experts who have just the solution to your problem.

- Limitless drug use and horrendous drug problems do not have to be the future of our country. In fact, they are highly unlikely to be. We can reduce both use and harm, but first we are going to have to do a better job of looking at what the problem really is and at what strategies are likely to be effective without creating even great harm.

We will only succeed with the problem of substance abuse to the extent that the underlying assumptions of our work are realistic.

Why do we see the use of substances as such a threat to our work environment? One very legitimate reason is that we feel an obligation to ensure a safe workplace that precludes individuals from operating with impairment that could potentially harm others. Is substance abuse the only way for an individual to experience impairment on the job? Clearly not. Employee

Assistance Programs and other workplace interventions recognize that many things, including family, financial and health problems, also have an impact on the way we work.

But are we as concerned about the fact that an airline pilot has gone without sleep as a result of personal problems, as we are if the same pilot is hung over? As individuals flying back in steerage, we don't much care; we want a fully capable and alert pilot. But as professionals and as policy makers, we seem to see a distinction that eludes the average air traveller. Substance abuse seems to have a more insidious connotation to us, one that justifies draconian (but ultimately ineffective) measures.

It is like the old story about searching for your lost house key under the street lamp because the light is much better there. If we tailor our definition of the problem to what we know how to do or simply to what we want to do anyway, I am not sure how much safer our workplaces are going to be.

Substance abuse, when treated as a unique threat to society, has the potential to undermine some of our basic freedoms. Consider the personal impact of urine testing in your workplace. Consider also other measures proposed or tried in the War on Drugs--increased police access to personal banking records, restrictions on international trade, zero-tolerance approaches to tourists that make going through a customs check an agonizingly slow experience, widespread covert police activities, search and seizure without a warrant, and so on.

This level of intrusion into individual lives is particularly disturbing. It implies that we have lost confidence in the ability of people to resist drug problems on their own. We need to discover that no drug has the power to turn a resisting, competent, healthy person into a dope fiend.

We need to rediscover a faith in our culture and in ourselves. This may allow us to develop and carry out other methods of drug control which depend more on individual and less on institutional strength.

In the workplace, this new way of thinking about substance abuse problems should move us away from treating drugs as if they have a power all their own. Specific drugs, like cocaine, do not themselves pose the threat. Impaired individuals--regardless of cause--pose the threat.

Substance abuse problems, like any problems which prevent the worker from performing adequately on the job, must be managed in a way which ensures the safety of the work environment and the rights of the individual.

I am firmly convinced that there are solutions to many--if not necessarily all--of our drug problems. I believe that employees, as well as employers, want a safe workplace and will work towards that if empowered and allowed to do so. However, this will not be achieved by the imposition of arbitrary solutions that make the evasion of the rules a game that all can play.

One should remember that one effect of the American urine testing program has been the growth of an industry that supplies drug-free, freeze-dried urine--with complete instructions. And, as someone who has been responsible for a methadone maintenance program that uses urine testing to monitor patient's drug use, I can assure you that the very people that you most want to catch are going to be very creative in finding ways to evade whatever protocols you put in place. The people you are going to catch are the ones that aren't serious about their drug use. Watching

people pee into little bottles is not part of a high-quality work environment. It also doesn't stop what you want stopped.

There are better ways; I hope this symposium will help you discover them.

A LABOUR PERSPECTIVE

Lillian Vine

Nancy Riche is the Executive Vice-President of the Canadian Labour Congress. She is the officer in charge of Technical Services, Political Action, and Special Projects (free-trade, GST). In this capacity, she is responsible for Research and Legislation, the Women's Bureau and the Labour College. Nancy is also one of the two labour vice-presidents of the federal New Democratic Party. She was first elected to the position of Executive Vice-President in 1986 and re-elected in 1988 and 1990.

Her interest in unions began when, as a business education instructor in her native St John's, Newfoundland, she became active in the Newfoundland Association of Public Employees (NAPE). Member of the NAPE Board of Directors was the first of several key positions that she has held, including Secretary-Treasurer of the National Union of Provincial Government Employees, Vice-President of the Newfoundland Federation of Labour and Director of Education, Research and Communications at NAPE.

Nancy Riche

I should start by stating my concern about the title of the workshop. "Substance Abuse in the Workplace" suggests what I think doesn't really exist as much as the title suggests it does.

We don't believe there is a major problem of substance abuse in the workplace. That doesn't mean to say that we don't believe there is a problem. The labour movement is not naive; we do know what is happening in the workplace and we talk to workers all the time. We know there is a lot of stress in the workplace. We know that the stress in the home combined with the stress in the workplace in many cases does cause substance abuse. We think that is going to get greater in the current recession; recessions affect a lot of people in a very real, personal, painful way. We also know that the degree of drug use or abuse in the workplace is significantly lower than the alcohol use or abuse. We do not accept that there is an epidemic in society or in the workplace. Health and Welfare Canada statistics show a decrease in alcohol consumption and marijuana use and a slight increase in cocaine use. We don't think that indicates an epidemic. The results of Transport Canada's own survey of workers in the transport industry did not have significantly different results. In fact, if you read through it, I think our greatest abuse in the transport industry is cold remedies.

Yet, the government in Ottawa has on its agenda to convince the public that not only do we have an extreme problem with substance abuse, but that the only response is drug testing. In fact, they started with mandatory drug testing. We totally reject this approach. We reject it because it is an invasion of privacy, a violation of human rights and civil liberties, an unreasonable search and seizure. I should tell you that if the legislation ever comes down there will have to be a challenge

to the government's position; we are currently in the process of preparing the Charter case right now because we believe there is one.

I am not sure exactly when this preoccupation with drug testing started. Others who are involved with the field on a day-to-day basis might have better information, but if my memory serves me correctly, either Nancy Regan or Ronald Regan said that there was a drug epidemic and Brian Mulroney, from the echo chamber, said "Me too." Every expert came out and said "This isn't true." It seems to me that ever since then, we have been fighting the issue, companies have been dealing with the issue, and I am not even sure there was an issue.

Others might say that that is not when it started, that it is a little more serious than that, that we have had big accidents in the country that were caused by drug abuse. A lot of people speculated that the Hinton crash was a result of drug or alcohol use. In fact, Judge Foisey found that alcohol and drugs were not a factor; but upon examining the workers' shift schedules, he did find that fatigue among the crew members was a major contributor to the crash. I am not sure that people involved on a day-to-day basis with developing policies in the workplace on substance abuse are aware of this. Somehow we got mixed up in the American problem and the American solution.

When the parliamentary committee responded to the Minister's strategy on drug testing, the footage CTV used in the news story was of the three airline pilots who were charged with being drunk in the United States. We are trying to deal with an American problem in Canada. It is quite frustrating to be able to get to the truth and honesty of the issue and then try to find the solutions. Sometimes we tend to look like we are reacting to it or suggesting that there is not a problem when in fact the labour movement recognized the problem long before Mulroney talked about an epidemic.

We believe strongly in treating the cause and not the symptom. In 1978, the Canadian Labour Congress passed a policy on drug and alcohol use using a union counselling approach jointly with the United Way of Canada. That agreement states that wherever we raise $1 million, the United Way with the labour movement will hire a labour staff representative. Right now we have 28 across the country and that number is increasing every day. That labour staff representative runs the union counselling program. The representative would be a trade unionist, be able to teach the union counselling course, liaise between the labour and social service communities, assist the United Way on union accounts at campaign time, and account to both the labour council in the community and the local United Way.

Let me say that union counsellors are not therapists; they are not trained or expected to be therapists. Union counsellors listen, refer to community-based resources, follow up to ensure that the co-worker is receiving the help s/he needs, and gives support when the co-worker returns to work following treatment. In addition to all of this, the labour staff representative is expected to pursue union action if in fact the occasion warrants it. For example, if the labour staff representative saw an increasing number of people involved with substance abuse from a particular department, or there was a higher level of anxiety from more people in that department, or if there was a higher level of sickness or absenteeism, was there something in the workplace causing that? If they had any indication that might be the problem, then that person would be expected to work with the occupational health and safety representative, labour and management, to try to correct the problem.

Quite often the union counsellors may work with others to provide a needed service in the community. They attempt to have rehabilitation centres in Canada so that we are not sending

workers off to the United States. If there is a service that is needed but not provided, then the labour staff representative will also be working in that area. Union counselling deals with problems in a nondisciplinary way. It is a peer-referral program.

The other major initiative we have undertaken, and that we believe has been relatively successful, is the joint employee assistance program. I emphasize the word "joint" because we believe that unless it is a joint program, it is probably doomed to failure. By "joint" we mean that the union is involved from the very beginning--union and management develop the program, implement the program, and monitor the program. In fact, if it is done in any other way, it will probably not work. If an employee assistance program is seen as disciplinary, then it is probably not going to help the workplace or the worker. In the whole area of occupational health and safety in this country, we have developed a cooperative approach that has worked. We probably have better occupational health and safety legislation than many places in the world because of this cooperative approach. So the joint program, we believe, is essential.

We believe that the employer is concerned about productivity and an increase in productivity. We believe the employer is concerned about how absenteeism and turnover rates can be reduced. We believe the union wants to know why this is happening if it is a problem that eventually ends up in substance abuse, because we want to look beyond that in the labour movement. We think we can help correct it. The basic elements to the joint EAP is that it would be joint; we want to make sure that before that development of the program, the union is absolutely sure what it is they are doing and what they want. We realize that this may be a long and tedious process, but we still believe that the effort must be made and we would support it over a private consultant. The most significant difference we see in the joint program is that we attempt to deal with the causes of workers' personal problems (on-the-job stress); we want to look at how the work is organized or managed (excessive heat or excessive noise); the stress that women never talked about was caused by sexual harassment over the years; racial discrimination that was allowed to go on year after year and that only now are we trying to deal with--our program tries to look at all of that.

We know that a worrisome situation at home combined with stress at work can push a person beyond endurance and the result could be alcohol or drug abuse.

To state the obvious, confidentiality is the key to the credibility and success of the program. The joint EAP is voluntary. We are concerned when employers see the program as a disciplinary tool--this is not acceptable to us. We believe the employer should assess the worker on job performance not on whether s/he thinks that the worker is an alcoholic, overweight or has a too active sex life. (There was a study in the United States that determined that a too active sex life makes a worker less productive on the job and so was seen as a problem.)

Joint EAPs are based on cooperation and trust. Once it is agreed upon, workers must be made aware of the program and how it works. We believe that we have found a better way. We didn't find that better way in response to the government's initiative, but because we saw a problem, dealt with it, and are still dealing with it in a way that works. We still strive for the society, the government, the employer to look at alcohol, drug, substance use and abuse in the way that Health and Welfare Canada referred to it and what we want to see is prevention, education and rehabilitation. We believe that is the way to reduce alcohol and drug abuse in the workplace. We believe that we have developed the tools to do this--the Union Counselling Program and the Joint Employee Assistance Program. We have experienced success. We have been lobbying very hard for Transport Canada to look at it in exactly the same way.

A COMPANY DEVELOPS POLICY

Lillian Vine

Ken Smith, our next speaker, will talk about the development of a company policy. Ken has been the Project Leader, Alcohol and Drug Policy Development in the Human Resources Department of Imperial Oil Limited. He is currently working on a special assignment to update and expand the company's policies and programs on alcohol and drug use. Ken has 12 years service with Imperial in a variety of head office and operating unit assignments. Most of his experience has been in the industrial relations, policy and human resources planning areas. Ken is a graduate of the University of Alberta and holds a certificate in Personnel and Industrial Relations from the University of Toronto.

Ken Smith

Imperial Oil is currently in the final phases of a policy development process which I think has been fairly unusual in terms of the length and scope of it and the amount of research and the degree of employee participation that it has involved. The process has been underway for about two years, and in the course of that time we have done exhaustive research and have found ways to involve over 50% of our employee population of 13,000 in some way. My role has not been to decide the policy but to orchestrate the process.

Imperial Oil is the largest petroleum company in Canada and being in the petroleum and chemistry industries, we have significant safety-sensitive operations. We also have a great diversity in the company geographically and in terms of occupations; there is a diversity in the organizational cultures of the different operating arms of Imperial, and a diversity of industrial relations systems (union operations, joint industrial councils, non-represented employee bodies and various employee communication processes). Like many companies in Canada trying to address the issue of substance use in the workplace, we are trying to do so in the midst of a very chaotic period of change. We merged with Texaco Canada in 1989 and we are still going through the throes of reorganization, restructuring and downsizing that typically follows those kinds of events. So it has been an exciting two years.

The reasons we are reviewing and updating our alcohol and drug policy are many. There is not a specific item--there is a confluence of different driving forces. Some of them are driving forces that have always been there. There is an ongoing concern about the health and safety of our employees, the public and the environment, and given that we are in a very safety-sensitive industry, there is nothing new in this. Recent trends have sharpened the focus of management attention on this issue. To be sure, one is the series of industrial incidents where substance use was implicated. In the minds of the public, substance use and these accidents are intertwined even if there were other contributing factors, and it does beg the question of "What if we had an impaired driver of a gasoline tank truck who crashes on the 401 and causes fatalities?" It is not hard in an industry like ours to conjure up very scary scenarios. This is one of the things that caused management to ask if Imperial had a robust, thorough, comprehensive program, but not the only thing.

Trends that started in the United States have partly provoked the current Canadian debate around this issue. Trends in public policy and media coverage have led to increased awareness of substance use in society and in the workplace. Myths and legends have also been engendered as

part of that coverage. It is more a case of heightened public and media awareness than good empirical evidence of an epidemic or sharp rise of substance abuse; the data show no such thing. In the legal arena, the Americans have a lot of legislated drug testing programs and now the Canadian government appears to be following suit in some areas through the Transport Canada proposals.

I think Imperial Oil would be in the position of having to re-evaluate what it is doing in the area of work-related substance abuse right now with or without some of these other trends. A confluence of things happening at the same time suggests that it is time to take a second look at what we are doing. There is the competitive issue--other employers are updating their policies and changing them. There is a technological push--new technologies for testing for alcohol and drugs beyond urinalysis; interactive computer performance testing; skin patch tests, and so on. We were concerned that our former policy was fragmented and incomplete; so we embarked on this exercise.

We did a lot of thinking before trying to write a policy. We realized we had to proceed with a lot of care and thought and not settle on an apparently easy but perhaps ineffective solution. Substance abuse has to be recognized as an emotional and complex issue; I would suggest to you the primary reason why it is emotional and complex in the workplace context is that it probes the boundary between work life and personal life. It is a well accepted principle in industrial relations in this country that what you do on your own time is none of the company's business. The difficulty with substance use is that use close to working hours carries over into the workplace. That dividing line is not pristine. That is one of the difficulties that have to be wrestled with and is part of why you get the very complicated and emotional issues around civil liberties. We felt it was very important to take the time and effort to thoroughly understand the situation, the issues, and the alternatives; to do the research on testing, peer referral systems, treatment, reinstatement, rehabilitation issues, aftercare, and so on.

We invited employee participation throughout the entire policy design process. We knew we would get a better quality product and better acceptance of the result, and that the policy development process itself could be a vehicle for awareness and education. There is a powerful impact when people jointly design a policy. The people who participated in our process without exception said that whatever agreements or disagreements they had, they learned a tremendous amount about this issue.

We felt we needed to take a comprehensive view of the issue; we did not want to take the narrow view of "war on illicit drugs," but to look at the generic issue of impairment in the workplace. Then, within that larger frame, look at substance-abuse-induced impairment, which would include alcohol, illicit drugs and the misuse of licit drugs, or even inadvertent impairment from the legitimate use of licit drugs.

Equally, it was important to try to strike a balance between the needs of all of the stakeholders in a modern business enterprise, and not in the traditional way--labour versus management. There are many stakeholders, some inside the enterprise and increasingly outside it--dealers and agents, shareholders, customers, suppliers, governments, and the public. All have a stake in having an impairment-free operation; all have different and legitimate needs which have to be balanced. Employees have a legitimate need to have their privacy respected and the public has a legitimate need to be assured that we are not going to have a vapour release from one of our refineries that will hurt people in their neighbourhood.

CCOHS/CCHST

Now I will explain how we went about this. The largest component of our policy development process was a series of intense three-day workshops with a group of 80 employee representatives from all parts of the company. We created for the first time in Imperial's history a "house of commons" for the company. We got a cross-section of people from the East and West, the upstream and the downstream, chemicals, head office, union leaders, representatives from our joint industrial councils, representatives of first-line supervisors, non-represented employees, and there were also the appropriate staff specialists (company lawyers, occupational health professionals, in-house EAP coordinators, security, safety, even a corporate ethicist). Senior management was actively involved through the two vice-presidents in attendance. Some very high-quality process facilitation is involved when you lock up a crew like that in a hotel room for three days to debate such an issue! There were three of these workshops plus a number of smaller meetings over a period of about a year and a half.

Between the workshops, the representatives went back to their home units and made presentations and held discussions about the issues that had come up and the proposals that were on the table. During that time I was coordinating exhaustive staff research on the legal aspects, the medical aspects, peer referral programs, computer performance testing, chemical testing, rehabilitation issues, relapse rates, and so on. Like the other participants in this process, I started off knowing very little but it is amazing how much you can learn if you focus on it for a while.

Another major component of the employee participation was getting some input from the people who weren't directly represented at the workshops. We did an anonymous survey of the entire employee population, which was administered by a third party research firm. The survey was overseen by a panel of employee representatives which included, among others, two union leaders, three or four people from joint industrial councils, and an EAP representative. Their job was to work with the research firm so that permanent anonymity of the respondents was guaranteed and that the right kinds of questions were asked. I could easily devote an entire presentation to the survey process and its results.

We had consultations with external stakeholders, including Exxon Corporation who is our majority shareholder, various people in government departments, and addiction research and treatment agencies. We had consultants survey the different position statements made by organizations in the addictions field, organized labour, the Privacy Commissioner, and Human Rights Commission which gave us a pretty good scan of the viewpoints different groups in society have on this issue. And of course there were regular senior management reviews. It won't surprise you that although we had this highly participative workshop process, senior management still reserves for the final decision 51% of the votes.

The workshop's mandate was to come up with a recommended policy, tapping into all the data sources, and put it before senior management. The task that is now before our senior management committee is to take inputs from the workshop recommendations, our survey results, Transport Canada's proposal, legal framework, perspectives of outside stakeholders, research, corporate values and how this policy aligns with everything else that is going on, and come up with a policy that meets the objectives. There has always been a high degree of consensus on the objective--wanting to have a workplace free from the use or effects of alcohol and illicit drugs, and from the misuse or avoidable negative effects of medications, so we can ensure the health and safety of employees, the public, and the environment.

During this process we learned that although the participative approach was time consuming and expensive, it was worthwhile. I think it created a significant increase in awareness and

understanding and the beginnings of a cultural shift in our company about how people regard substance use as it relates to the workplace.

We began with a macro version of the denial that an individual substance abuser sometimes has--we had an organizational denial. After completing the survey and the research we found out that we do not have an epidemic, but the problem is there. We do have some employees who misuse these substances in close proximity to work and sometimes that contributes to accidents, near misses and other negative effects in the workplace. The process caused us to re-examine some fundamental assumptions. Some of them were areas that we hadn't thought of addressing initially, such as company policy on alcohol at company-sponsored social functions. No one initially thought that was part of the mandate, but when you start thinking through the problem, gut-level questions emerge.

Fundamentally, we learned that this a question of striking a balance--a balance between policy measures that are based on employee commitment, like awareness and education or peer referral programs, and policy measures that have more of a control orientation, that management may feel it needs to discharge the duty of "due diligence" to ensure safety. There is a dynamic tension between the need for safety and the need to respect individual privacy and to support the individual who has a problem and needs help. There is a need to balance those policy components which focus on the broad majority who do not have a substance abuse problem and those policy components that deal with those who pose a risk to themselves and others.

QUESTIONS AND DISCUSSION

Tammy Robertson - Alberta Alcohol and Drug Abuse Commission

Many of the clients in the petroleum industry where work is in isolation and not closely supervised. These people work in seasonal work in safety-sensitive positions. Sometimes they feel that the only alternative is drug testing and that as a deterrent, it is effective. I am wondering what other kinds of responses we could give them about what they can do. What can I tell them? I can't send them to an EAP because there is nothing in the area.

Ken Smith

I think you have put your finger on one of the most difficult circumstances in our industry--people in safety-sensitive work in relative isolation. Peer-referral programs can be very effective, but they presuppose there are peers around to see what is going on.

Nancy Riche

The first thing we look at are workplace conditions. Start with the question of people working in isolation--what can we do about that? Can there be a rotational shift for these workers, can people do other kinds of work? Once you identify that one of the major reasons for the problem is isolation, then look at what can be done about that isolation.

Tammy Robertson

There doesn't seem to be a lot that can be done; it is the nature of the job. Drug testing has been effective in terms of deterring people. At least that is the feeling I have received in talking to our clients.

Jan Skirrow

I don't think there is any easy answer to the issue you raised and there is probably very little you could do to prevent a one-time accident where someone goes out, gets drunk, comes in the next morning, drives a truck and has an accident. But I think what you are sensitive to is a pattern of behaviour in a person that suggests to the observer that there is something going on. I think back to a long time ago when I worked for a brief time in the oil patch. We were sending men out--one man to a truck--and they would go out to some of the more remote locations, and not working out of a central office, in various jobs. Every one of those men would socialize in the nearest town with his fellow workers who were also working in isolated locations, sometimes with suppliers, sometimes with people from head office, certainly on the weekends. There was a loose social network of related workers and it was different from what you would find in an office in the city. I think these informal kinds of processes can work, you just won't be sure that you have a good handle on the situation. But I have rarely seen someone get into difficulty with drugs and alcohol that had not given a lot of warning over a long period of time.

Linda Wilcott - Canadian Labour Congress

I would like to make a comment about deterrents. I don't think there is any statistical evidence or proof as to whether or not drug testing is a deterrent. I think if you are a drug addict you will find ways around it.

I wanted to make a point on the issue of union counselling and employee assistance programs. I want to emphasize the issue of broad-brush programs. We are talking very much about alcohol and drugs and I think we need to say all those programs have to deal with the broader issues of marital, financial, and all the other experiences of daily life to deal effectively with the issue of alcohol and drugs.

Jan Skirrow

I would like to make a further comment on the deterrent issue because I think it is important. It has become fashionable to say that deterrents don't work; I don't think that is a fair assumption across a range of issues. What is really important is the perceived risk of being caught and what happens when you are caught. If the perceived risk is very low, then it is not going to have an impact on behaviour. On the other hand, the difficulty of making the real risk high is extremely difficult no matter whether it is a workplace or impaired driving. What you see in our field is that when a company introduces a plan or the government introduces a program there is a lot of attention and public relations activity. Everyone gets very paranoid and behaviour changes. Once people begin to see what the true risk is of getting caught, behaviour tends to resume the previous pattern. I am concerned with the data that has come out now is extremely short term. I would expect, given all the fuss, that most employees would decide to watch themselves, but after a while they discover that the chances of getting tested are low and the chances of getting caught are not great, and if they do get caught they go for four weeks to a treatment centre somewhere and then come back on the job. So the issue is will that sustain behaviour change over time?

A BUSINESS PERSPECTIVE

Lillian Vine

This is just about a premiere performance. Sanderson Layng has been president of the Alliance for a Drug-Free Canada since April 1, 1991. Prior to joining the Alliance, he was the executive producer and national coordinator for Concerned Children's Advertisers, a consortium of businesses which advertise primarily to children.

Through these involvements, Sanderson has worked closely with his co-sponsors, the Canadian Association of Chiefs of Police, Health and Welfare Canada, the Reader's Digest Foundation and the Canadian Centre on Substance Abuse.

Before he was involved in drug education, Sanderson served as a communications consultant to the United Church of Canada, the Department of Communications, TVOntario, the CBC, the CRTC, the Canadian Cable Television Association and many others. From 1981 to 1988, Sanderson took a break from running his own communications firm to serve as a president of the Canadian Captioning Development Agency which developed closed captioned television for Canada.

He has studied adult education at the Ontario Institute for Studies in Education and taught for three years in the Business School at Sheridan College. Sanderson was the editor of Television Awareness Training and is co-author of "The New Communicators."

Sanderson Layng

Thank you for inviting me here today. I want to tell you a little about the Alliance and tell you where it is going. I am pleased to follow Ken Smith of Imperial Oil; Imperial Oil is one of the prominent members of the Alliance and its drug policy development is indicative of the kind of work the Alliance supports and encourages.

The Alliance is a consortium of top business leaders and other prominent individuals in the country who came together to address demand reduction for harmful substances in the workplace and in our society. Representing business, we feel we are the ones with the strongest vested interest in solving problems in the workplace and in society, and we don't necessarily distinguish between those elements. At a very base level, there is a straight economic reason for the business community to be concerned about the issue of drugs in our workplaces and how it affects our employees and productivity. It gives us motivation to be extremely clear, but it is not the only reason we address these issues. We can't afford to only describe the problems--we have a vested interest in solving them. It has been my experience in my career, that when I talk about social issues and concerns--the hearing impaired, the Canadian National Institute for the Blind--in trying to raise money and trying to promote social services and development, I have always gone into the business community with a straight economic argument. It has always amazed me when they tell me that they get involved in these social issues because they believe in them, they believe they are the right things to do. This was an extremely refreshing and unexpected result of these contacts.

The Alliance is a group of people that came together because of concern about the economics of workers not being able to perform and/or show the kind of productivity that management is

concerned with. But they are also concerned about people, concerned about having healthy and safe working environments because they believe in them for their employees and for themselves.

I heard about the Alliance a year and a half or so ago--I heard that it was a right-wing business excuse to drug test anything that moves, with an American branch-plant approach to Canadian problems, which focuses exclusively on illicit substances as if they were a huge problem in this country to the exclusion of real problems such as tobacco and alcohol and the unhealthy use of prescription drugs. As a drug educator I was shocked that the business community I had come to know would be described in this way. So I went to see them and we had long talks about what the Alliance was really about and what it was really trying to accomplish. I liked what I found so much, I joined the company.

The Alliance is a charity; its purpose is information and education concerning drug awareness. We work in three primary areas. One is a workplace initiative that looks at a drug-free workplace. We have an office in Ottawa that devotes itself exclusively to that activity with a helpline and by producing a variety of resources--educational materials, booklets, videos, that address the issue.

Although we are also involved in public awareness campaigns and in community projects that address children and teens and parents, I want to talk primarily today about our role in the workplace. We have a basic five-point program whose first and foremost element is a corporate policy. We encourage Canadian corporations to develop a policy on the issue of drugs in the workplace. Our contact is directly with the CEOs--the people who determine policy and who implement policy decisions. Secondly, we promote education and drug awareness at all levels of the company, including the CEO, the officers, the executive, the supervisors and the employees--everyone from top to bottom. We feel that for an organization dealing primarily with demand reduction, education is the best approach. We also hold seminars across the country that deal with issues such as security; these are well attended by people from human resources, from EAPs and from other areas of the company.

In promoting all of these activities, we are often asked why the Alliance's focus has been illicit substances. Very simply, it is because it is the area least understood within our member companies, the one that companies tend to have the least information about; for example, the security and legal issues that come into the picture are often not understood by our members.

The Alliance does not encourage setting up EAPs to deal solely with illicit substances; we encourage comprehensive employee assistance programs that deal with all problems that lead to impairment because these issues are not segregated. You can't look at an issue of illicit substances and not look at alcohol; the use and the abuse of drugs is not the issue in and of itself. We have to look deeper to why and how and what and deal with the issue in a comprehensive way. So we provide companies with examples of EAPs to help determine what is right within their own companies.

The next issue is security. Canadian businesses need to know how to deal with illegal activities related to substance abuse in the workplace. They need to know the laws in Canada and they need to know their liabilities.

Finally our last point is drug testing. I will first tell you my personal views on the subject. I value my privacy heavily, and I am a strong believer in individual rights. I don't like that the City of Toronto tells me where I can plant flowers on my front lawn or the quality of the light bulbs that I have to use on my front porch. I don't like that I can be detained by the police

without probable cause by the RIDE program. When I go to the doctor and have to perform all those little tests in the privacy of his office, I am very uncomfortable. The idea of doing that at work chills me. On the other hand, I don't want my neighbour to plant corn in his front lawn; I don't want someone who is driving a car while impaired by alcohol to be out in the street at the same time as my wife and daughter; and I want to be able to work somewhere where I have reasonable assurance that it is a safe drug-free environment and that I am not going to be in any danger as I travel or that someone isn't going to run me down with a fork lift while impaired by some substance. So I am always caught in a dilemma when looking at issues such as this one. I have come to the decision over time, that even though I object to personal infringements, there are certain social conventions to which I am forced, and willing, to submit. As a television producer I didn't wear a tie very often; since joining the Alliance there is a convention that when you are going to beg for money, you should be at least as uncomfortable as the guy you are begging from. So now I wear a tie. There are a number of other conventions that I am willing to submit to if I believe that they are going to provide me with some level of security and a sense that any infringements on my personal freedoms or my individuality are working towards some eventual common good. The issue is finding balance. Even though I don't like that I can be pulled over in my car, I accept that it has significantly reduced the number of people who are impaired and out driving in the street.

That is my personal view of the issue; my personal struggle between what is good for society and what is good for safety and what may not be my first choice, but may be in the best interest. I believe society is at its best when it attempts to find the balance point and so is the Alliance. Now I want to tell you the drug testing policy of the Alliance for a Drug-Free Canada. The policy statement reads:

> As a charitable organization that provides information and educational services to promote drug awareness, the Alliance does not advocate a universal position on drug testing, recognizing that each corporation is different, has its own management practices, employment philosophy, and problem solving procedures. One all-encompassing employee drug testing/screening policy is not possible nor desired. The company, therefore, must feel free to follow its own dictates in this sensitive area, taking into account corporate mission, legal advice, available legislation, jurisprudence, and its own research. The Alliance mandate is to assist companies in a comprehensive and competent review of the issues and research related to drug testing. And should a company at its sole discretion decide to implement such a program, the Alliance is prepared to assist in the development of excellence in such programs. The Alliance will acknowledge the leadership initiatives of companies which provide for thorough examination on this issue regardless of the eventual decision as to the suitability of drug testing in that particular company. The Alliance, therefore, encourages dialogue on the subject and does not promote a particular result.

Accordingly, we are extremely happy to be able to be here today because this workshop is a terrific example of the kind of activity that the Alliance promotes with respect to drug testing; that is to have a variety of perspectives and a great deal of information so that people can look at the issue and decide for themselves which way they want to go. It is an extremely controversial and sensitive subject. But it is my belief that through this kind of exploration and review, companies will eventually develop policies that I, as an individual, will be comfortable with. So in a lot of ways, the Canadian Centre for Occupational Health and Safety as an educational

organization and the Alliance have extremely consistent and mutual interests in terms of exploration and influencing points of view and the benefits that come from discussion.

I joined the Alliance because having worked in the area of producing information for children and teens in dealing with drug awareness, I have found that children and teens are incredibly overserved. They know so much about all the issues involved and until parents bring home from work the same level of information, we are not going to find the kind of dialogue around the kitchen table that I think should be going on. I think the workplace offers a tremendous opportunity to provide parents with information that they can use in just such discussions. Because of its vested interest and its opportunity to deliver and provide for education, business is redefining the workplace as a place of learning. I think business has a tremendous opportunity to provide educational resources. When companies across Canada have policies that address drug-free workplaces, we have the potential for drug-free communities and eventually for a drug-free country. I think we are well on the road to that. I think we can make significant advances and move that cause along a lot farther through the kinds of educational programs that the Alliance can provide. Towards that end, I would like to welcome all of you to join with us. I invite you to join the Alliance as a member, to participate in our drug-free workplace advisory committee, to help us identify and assess the issues and to make our programs in search of excellence get there faster. We welcome the participation of all parts of the business community in doing that. We welcome labour, we welcome unions, we welcome everyone that can help advance this cause. So I hope you will take a look at the new and improved Alliance for 1991, and you will see fit to join with us.

A WORKPLACE HEALTH PROFESSIONAL'S PERSPECTIVE

Lillian Vine

Our next speaker, to discuss the occupational health and safety professional's perspective, is Dr Ian Arnold. He was born in Toronto and attended primary and secondary school in Ottawa before completing his doctorate at Queen's University in Kingston. A rotating internship and four years of general surgery training followed leading to certification and a consultant post in that specialty. The years 1973-1981 were spent in Labrador West as Surgeon-in-Chief at the Captain William Jackman Memorial Hospital and as Surgical Consultant to the Fermont Medical Clinic.

Ian's interest in occupational medicine started in 1975 when he was a consultant to Quebec Cartier Mining Ltd at Mount Wright, Quebec. In 1978, he became the Medical Director of the Carol Project of the Iron Ore Company of Canada. In 1981 he was appointed Senior Medical Consultant in Occupational Health for the Alberta Government and took over the Directorship of the Medical Services Branch in 1983, a position he held until joining Dow Chemical Canada Inc in 1984 where he is now the Corporate Medical Director.

He holds a diploma in Occupational Health and Safety from McMaster University, is a Certificant of the Canadian Board of Occupational Medicine, and is a Fellow of the Royal College of Physicians and Surgeons of Canada in Occupational Medicine.

Ian has held appointments with the Faculties of Medicine at Memorial University in Newfoundland, the University of Alberta, and the University of Calgary. He is currently an Honorary Lecturer in the Department of Pharmacology and Toxicology, Faculty of Medicine, at

the University of Western Ontario. He is President of the Occupational Medical Association of Canada.

Ian Arnold

The purpose of my talk today is to examine substance abuse from the occupational health professional's perspective. I am going to focus on that area. I want to review also some of the issues that surround that role.

I am defining the term "occupational health professional" to ensure that we are focusing on the same thing. There are a lot of other members of the occupational health team besides the ones I will refer to. In this reference I will be talking about the occupational health nurse who may have certification in the occupational health nursing field, who may have a diploma or certificate from a community college, or who may have practical experience. Occupational health physicians, the doctor side of the equation, may be at a fellowship level certified by the Royal College of Physicians, may be board certified by the Canadian Board of Occupational Medicine, may have a diploma, or, as many occupational health practitioners do, have generated their expertise from working in the field over a number of years.

The primary focus of the occupational health professional is employee health and there are a lot of variations and ramifications. From the substance abuse perspective, the first concern is the prevention of substance abuse problems to help protect the health of all the employees in the workplace. The second is to assist the employee who does have a substance abuse problem towards appropriate rehabilitation and return to a productive work and home life.

The roles that I see for the occupational health professional are five-fold: policy development; promoting the policies; education of the workplace on substance abuse; education of key players; and assisting the troubled employee. There are a lot of roles to play in the development process and in the promotion process.

We heard earlier an excellent talk on process in policy development through a team approach. If you are a small operation, you may want to just have two or three people on the team--a human resources person, someone from the legal profession, an occupational health professional. Worker representatives are very important in the development process and line supervision should be part of the team as well.

Why involve the occupational health professional in the policy development process? The occupational health professional is an individual who has knowledge of the health effects of substance abuse and therefore can contribute from that perspective. S/he also has knowledge of use patterns and workplace effects of substance abuse. S/he may have access to the appropriate treatment centres or referrals for the individual who needs assistance. There are many reasons to involve the occupational health professional as a player in the development process.

I have spoken about awareness and education. Awareness comes from delivering information that is added to one's knowledge base, not trying to change behaviour or develop new skills. In a workplace, our target audience would include employees, it may include employees' families, it may include local community assistance resources.

Occupational health practitioners have an advisory role in promoting awareness and talking to people about it, either when they do health assessments or on a scheduled program basis

throughout the organization. The policy owner, however, should be the primary promoter of the policy and use the occupational health practitioner as a resource.

Education is the acquisition of knowledge and skills, whereas training is the deliverance of a specific set of skills that changes one's behaviour when the skills are used and addresses a specific performance gap. We are looking at a graded approach from awareness, to education, to training as we become involved in the program.

The occupational health professional has a significant role to play in this process. We have talked about awareness, we look at the education and training, we can assist in helping the employees and their families to understand health effects and recognize problems, and we can refer people to appropriate sources for assistance.

Certain employees need some additional education and training. These might include supervisory personnel, security specialists, employee assistance program team members, union stewards or officials and joint health and safety committee members. I chose these positions because I see them as key roles in trying to assist people and trying to identify performance problems so they can get the employee to some form of appropriate assistance.

These key players need additional education and training because they need to understand concepts such as enabling. They are the people who are most likely to detect the troubled employee. And the ones most likely to be approached by an employee for assistance.

Occupational health professionals have a role in assisting the employee with a problem because they can help in the identification of that person, they can work on the assessment of the problem and look at its impact on the employee and on the organization. They can develop a treatment plan for the employee. They have the ability to interface with the company, with the union, with the treating agency and with the family physician. Finally, they are in a position to do an appropriate follow-up.

Those are the roles as I see them for the occupational health professional. One of the issues from the occupational health professional perspective is determining the size of the problem. I have found it difficult to find very specific hard data on the scope of the problem in Canada. Very few people are doing testing, very few people keep strong records of EAP referrals and the reasons for them. Most data seems to be inferential from general population usage data. Alcohol abuse seems to be a lot better quantified than drug abuse. A few numbers that I have heard, and these are probably survey numbers rather than study numbers, are 10% of applicants for safety-sensitive jobs in the railroad industry are testing positive for illicit drugs; 5%-10% of the general population has alcohol related problems; 10% of fatal workplace accidents were positive for alcohol, 8.5% for prescription drugs, 8.5% for marijuana and 6.7% for non-prescription drugs; alcohol use during working hours - 22%; street drug use - 1%. So there are some numbers available, but they are not very solid and some of these numbers are survey- and not study-generated so they have all the faults related to those methods of number generation.

How do we go about developing data if we aren't happy with the data available? We may have access to data such as on known referrals, types of problems that have been referred already, success factors that may already be present in our workplaces or in our union data banks. We may have data from employee assistance programs; it may not be that solid but it will give an indication of what is going on. An anonymous survey which will give some idea of use patterns of various types of alcohol, drugs, prescription drugs, etc., may also be used successfully.

The next issue is probably as much a societal one as an issue for an occupational health professional, except that the occupational health professional is sometimes at the centre. We may know of an employee substance abuse problem; we may know it because s/he came to us to facilitate referral for assistance. We are faced with the question "Does the substance abusing employee put other employees or the community at risk?" If s/he does, how do we handle this problem if the individual will not or does not seek treatment? We are left knowing something and yet we have no solution to it. Work restrictions may be a reasonable short-term method to accommodate the illness and the need to protect others. I have found that this can work in some situations. Unfortunately, it doesn't protect the individual who also has a major performance problem, it doesn't acknowledge the cause of the performance problem, and eventually it may lead to separation from the organization.

How do we separate the roles of policeman and helper? The traditional medical role is one of assistance--we are trained to help people who have problems, help people get to better health. Our role in substance abuse must remain the same. I have spoken to a number of colleagues in occupational health and they all feel very strongly about this--we have an assistance role, we have an education role, we have a prevention role; we do not have a policing role. The occupational health professional is required by regulation or by Act to maintain confidentiality unless there is written permission or where there is a legal requirement that supersedes confidentiality.

I believe that disciplinary aspects should be separated from the assistance perspective. Discipline relates to performance not to illness. Substance abuse from my perspective is illness-related.

Another issue we get caught up in is drug testing. Yes, no or maybe? I am not sure of the answer and one of the reasons I am here at this workshop is that I want to hear what other people have to say about it. I have a pretty good personal perspective of the occupational-health-professional role but I am not sure about the whole question of substance abuse testing.

What about the involvement of the occupational health professional? There are arguments on both sides of the question and I will outline them. Should the occupational health professional be responsible for a substance abuse testing program? Those who say "Yes" say that abuse is a health issue. The occupational health professional is in the best position to assess and assist the employee. Another reason for keeping it within the health centre is that results would not be available to the organization without written consent. And the occupational health professional can best assess fitness for work.

Those who say "No" say that the results are not available to the organization. The occupational health professional is not in a position to insist on treatment as a management person might be. The only options are work restrictions or to declare the worker unfit.

Those who say "Maybe" say that the occupational health professional does act as a resource to assist the employee with a problem either as a part of, or separate from, the employee assistance program. This presupposes a sharing of results between the part of the organization which carries out the testing and the occupational health professional. Somebody else does the testing, results go to both parties so that the occupational health professional has a direct chance to assist the employee.

If we are speaking about impairment from substance abuse, then we can't ignore legal drugs, prescription drugs and alcohol as part of the picture. An employee who is taking prescription drugs should declare this when being tested. Lead time has to be given before the start of a

program. Chains of custody must be developed and documented. Many issues, apart from who runs the program, have to be considered.

From an occupational health professional's perspective, I believe that we do not have a role in running a testing program or being a direct part of it. The role of the occupational health professional is to try to prevent problems and to assist the employees with problems towards rehabilitation. I feel that if occupational health professionals are part of the testing program it may reduce their ability to assist. Some of my colleagues feel that the number of self-referrals would fall dramatically if the occupational health professional was in a policing role. For those reasons, I feel and our association feels that the occupational health professional has a major role in assistance but not in specifically running a testing program.

The occupational health professional should be an integral part of the program--developing the program, educating people, holding awareness programs and training programs. Awareness, education and training are the keys to prevention. If substance abuse testing is done, the occupational health professional must keep what information he receives confidential. Occupational health professionals have a significant role in assisting the abusing employee with rehabilitation. I don't think they should be running the testing program; I don't think that they should be the primary owner of it. I believe occupational health professionals have a very major role in the areas of awareness, education, training and assistance.

TREATMENT

Lillian Vine

Garth Martin holds a Master's degree in Social Work. He has been active in the addiction field since 1972; his experience in the treatment of young drug users includes working as a therapist and Head of the In-Patient Drug Unit for eight years, and as co-investigator of the Young Drug Abusers Study, an experiment on the efficacy of in-patient versus out-patient therapy. He is currently co-investigator of a comparative study of family versus individual therapy in the treatment of adolescent drug abusers. He chaired the provincial Advisory Committee on Drug Treatment which recently produced the report "Treating Alcohol and Drug Problems in Ontario: A Vision for the Nineties." He is Assistant Director, Research Dissemination and Head of Social Work at the Addiction Research Foundation. He is a candidate for a PhD in Social Work at the University of Toronto.

Garth Martin

Yesterday I happened upon a cartoon which seemed apropos for this presentation. It showed a character sitting in a room amidst a pile of books staring at one particularly large volume. The caption was "By God, for a minute there it all made sense!" My task is to try to make some sense of treatment.

<u>What is treatment?</u>

It may be useful to start with a definition of "treatment" and I thought I would read to you what the Advisory Committee on Drug Treatment had come up with: "Treatment is an organized set of

assessment and therapeutic activities with the objective of assisting clients in the reduction or elimination of problematic use of alcohol and other drugs, and improving and/or maintaining functioning in one or more dimensions of health." There are some important aspects of the definition that I would like to emphasize.

When we talk about alcohol and other drugs, we mean the wide variety of substances that people may be using, including tobacco which is increasingly being recognized as an important consideration in treating alcohol and other drug problems, not to mention being an important substance of abuse in itself.

The definition also said "assessment and therapeutic activities" and by that we mean that treatment really involves a range of activities that include identification, detoxification, assessment and referral, a variety of structured programs or interventions, and aftercare.

We say that treatment is aimed at the elimination or reduction of the problem. Ideally, elimination should be the outcome of treatment, but we need to recognize that to reduce the degree of harm associated with substance abuse problems is also of benefit. It is naive to think we can eradicate the problem entirely and, realistically, for many individuals with problems we should aim to reduce the impact of the problem if we cannot eliminate it entirely. So we have to consider "harm reduction" as a reasonable and important objective of treatment.

The definition emphasized that treatment also seeks to improve or maintain the functioning of individuals in other life areas. That is to emphasize that treatment has to address the whole person. We need to look at the variety of areas of functioning and ensure that we address issues of social, psychological, physical and spiritual wellbeing when we address the substance abuse problem.

What do we do in treatment?

We try to help people in a variety of ways in a variety of programs:

- We want to help people withdraw safely from alcohol or other drugs.
- We have to identify and treat medical complications that may be associated with substance use.
- Treatment may serve to develop coping skills to help people deal with the situations that put them at risk of relapse following treatment.
- Treatment often serves to enhance self-esteem and improve the quality of interpersonal relationships, especially family relationships. We know from studies of natural recovery that having meaningful relationships seems to be a critical factor in the recovery process, so we need to address these relationships in the treatment context.
- Treatment aims to develop understanding and insight.
- It often involves teaching practical skills to deal with substance abuse problems, skills to reduce actual drug taking behaviour.
- Treatment attempts to help people develop support systems because we know that those who have good social support systems are the ones who do the best in treatment, the ones least likely to relapse.
- Treatment helps add meaning to life, it helps people develop leisure interests, it may teach basic living skills, and it helps people enhance their vocational interests or their career options.

- In some instances a structured, protective and supportive living environment is provided as part of the treatment process.
- Treatment sometimes deals with underlying psychopathology.
- It may even involve giving people drugs.

A lot of different things are done in treatment; what is done depends on the theoretical orientation of the program and the characteristics of the population being served. Ideally, client needs should be matched carefully to what the treatment provides. It doesn't make a lot of sense to think that we can deliver treatment packages that everybody in the treatment program will benefit from. Individuals are different, they have different needs and it is becoming increasingly clear that the more we concentrate on meeting those needs in an individualized way, the more effective we will be in treatment.

Treatment can take place in hospitals, community-based agencies, employee assistance programs, and self-help groups. It may involve out-patient counselling, day programs, evening or weekend programs, or residential programs which may last from one month to six months or a year or more.

EAPs play a crucial role in the treatment process, primarily in identification, assessment and referral, and out-patient counselling. But it is also important to emphasize the role EAPs can play in: case management--ensuring that the needs of the person are being met in an integrated, coordinated, and comprehensive fashion; and aftercare and re-integration--making sure that there is support for the individual on return to the work setting and to ensure effective re-integration on the job.

Treatment may be provided by professionals with specialized training or it may be provided by individuals who have recovered from the problem if they have developed specialized skills in helping others. In all cases there should be a program of aftercare because we do know that relapse is a chronic condition of alcohol and drug problems; it is the rule and not the exception that people relapse. We have to recognize that relapse is not necessarily an indication of failure, that the high rate of relapse does not mean treatment is not effective. Rather, relapse is a common aspect of recovery from alcohol and drug problems.

Does treatment work?

That question gets asked fairly often and for some reason it gets asked a good deal more with respect to alcohol and drug problems than it does for other types of problems. I think that reflects how we as a society and as professionals feel about alcohol and drug problems. I would suggest that it suggests a more moralistic approach to alcohol and drug problems than to other problem areas where we often have even less research support for treatment efficacy.

One answer to the question "Does treatment work?" is: "When it is done well, it often does." If we take the average of results from a large number of treatment outcome studies, we find that generally the old rule of one-third applies--a third of the people will be successful; a third of the people will make significant improvements; another third will be no better or worse following treatment.

We do know that the characteristics of the client entering treatment have more to do with outcome than does the type of treatment provided. For example, clients who have less severe dependency, fewer other problems, more social support, and more socially stable living situations have much

higher rates of recovery than people who have more severe problems, more problems generally, and lack social support.

In the past, it was thought that an individual must "bottom out" to be ready for treatment. That is a myth--we have clear evidence that those people who have not "bottomed out," that is those who have lost less in the process of their addiction problem, do the best in treatment. This fact is now so widely recognized that those who previously emphasized the need to "bottom out" now talk about "raising the bottom" as a means of trying to develop commitment to change sooner in the process rather than having to hit the absolute bottom. This research evidence clearly points to the importance of early intervention. Workplace settings are one of the crucial places where early intervention strategies can be implemented and EAPs have made a good beginning in that respect. We have to catch people earlier in the process when problem indicators are perhaps more subtle and not just wait until those problems have become so severe that they could not possibly escape notice.

We are also beginning to discover that treatment is a pretty good investment. There haven't been many studies of this type, but those that exist show that the costs of treatment are often offset by its benefits, such as reduced health care cost and, in the case of illicit drug users, increased productivity and reduced criminality.

What are some of the issues in treatment?

First there isn't any single treatment approach that is best for everyone. We need to be able to match people to the right type of treatment. In fact, it seems that the characteristics of the therapist may be more important than the type of treatment program. What we are finding is that characteristics of the client make the biggest difference to outcome, followed by those of the therapist. The nature of the treatment program may have the least impact on outcome. The ability of the therapist to relate and to form a trusting relationship with the client contributes to the client's willingness to work together to solve the problem.

Is alcoholism or drug addiction a disease?

This is one of the hotly-debated issues in the field but from a practical, clinical perspective it may not matter. For example, I attended a presentation by Dr Jean Kirkpatrick who is the founder of a self-help group for women called Women for Sobriety. She was describing alcoholism as a disease and going on at some length at the beginning of her presentation to explain why she thought this was so. She then described the nature of this peer-support group approach to dealing with alcohol and drug problems in women. I couldn't see what difference it would make whether alcoholism was a disease, given the nature of the Women For Sobriety approach which places a heavy emphasis on empowerment as a process and social support to help women overcome alcohol and drug problems. I asked her what difference it would make to her program if researchers, tomorrow, demonstrated conclusively that alcohol and drug addiction wasn't a disease. She admitted it would make none. The real questions are: Are addictions a health problem? I think the answer is yes, they are. Should we respond compassionately to people to overcome these problems? Yes, we should. But, are individuals responsible for their behaviour? Yes, they are. They have choices and they make choices.

And so what about motivation? We don't have any treatment methods that work independent of people's willingness to change. But that doesn't mean that we as treatment providers should simply say "If you don't want to change, that is your problem." Nor does it necessarily mean that

confronting denial is a solution in every instance. Motivation issues are more complicated than that. We are now coming to realize that motivation and developing commitment to change may indeed be the most critical part of the treatment process; once people have a firm commitment to change it is usually very much easier to help them change. Many different treatments seem to work very effectively. It is much more difficult when people haven't developed that commitment to change. This lack of commitment may reflect their perspective that the benefits of giving up drug use don't outweigh the benefits of using drugs, or their fear of failing in this as they have in so many other areas of their lives.

There are many routes to the development of commitment in individuals: simple feedback can help people, such as sitting down with a person and explaining some of the health problems associated with alcohol use. Another approach involves bringing significant others (family, friends, colleagues) into the process, to share their concerns and to bring a perspective on the problem that is more difficult for the individual to deny. This doesn't have to be a harsh confrontation process; it may simply be a consciousness-raising one. We should usually start by trying to ease people into recognizing that they need to change rather than beating them over the head to convince them they have to change. We must provide encouragement and support to help those who lack confidence in their ability to make those kinds of changes. Clarifying mixed feelings is also important. It is not unusual for people entering treatment for an alcohol or drug problem to be ambivalent about change; this ambivalence has to be treated as real and not necessarily an indication of denial. In some cases more draconian measures may be indicated, but not usually at the outset. Precipitating crisis is one way of helping people come to grips with the kind of problems they have. By this I mean essentially, "don't bail them out." If they see that their actions have negative consequences, this may create a willingness to think about doing something different. A crisis is a period during which most of us are most open to change and we have to take advantage of that opportunity to increase commitment to change when it arises.

Taking a goal- rather than a problem-orientation is another approach to motivating people. My view is that if you can get a commitment from a person to change it doesn't matter whether or not s/he admits s/he is a hopeless alcoholic--it is the commitment to change that matters. Some may avoid admitting to a problem and yet still be willing to commit to change.

We must also be open to the option of moderation as a possible goal in treatment. I know that this issue is extremely contentious, but those who are working in occupational health settings must be willing to consider this option if they wish to appeal to individuals early in the development of their problem. In an early intervention program you can forget about appealing to people if you insist on calling them "alcoholics" and requiring them to be abstinent for the rest of their lives. There are people for whom abstinence is the appropriate treatment goal. But if we want to reach people earlier in the process, we have to be open to the idea that some may choose, realistically, to cut back consumption rather than cut it out entirely.

Much has already been said about drug testing in the workplace but it is an issue which can also be addressed in the context of treatment. In essence, I would say that treatment is a voluntary contract between an individual and a therapist, and while drug testing may be useful clinically, if it is a mandatory component of the treatment it can become a barrier in the treatment process. However, there are ways to use drug testing effectively when the client and the therapist agree that it will be helpful.

What is the vision of the future?

One aspect of such a vision is more emphasis on early intervention programs. If we are going to be more cost-effective in dealing with problems we need to get at them earlier. The workplace, schools, family doctors are important contexts in which early intervention strategies can and should be implemented.

We also need to have a greater concentration of programs in the places where the people with alcohol and drug problems are typically found. There are two major service areas which exemplify this need: general hospitals because estimates suggest that 20%-30% of patients in a hospital at any given time are there for reasons related to alcohol or drug problems; and correctional settings where estimates suggest that upwards of 75% of inmates have alcohol and drug problems. Very frequently these problems go undetected and nothing is done about them.

The last point I would like to make about a vision of the future is that we have to de-emphasize residential treatment. The evidence from many treatment outcome studies now suggests quite clearly that for the majority of individuals outpatient treatment is just as effective as residential treatment. This evidence is certainly at odds with what a lot of service providers believe so we have, in the province of Ontario for example, about half the people being treated in addiction-specific services treated on a residential basis. This is not consistent with what research suggests should be the case. Occupational settings should play an important role in this process because research suggests that people who are employed and more socially stable don't usually need costly residential treatment. For the same cost, about 8 times as many people can be treated on an outpatient basis as on a residential treatment basis. It is estimated that at any given time only about 10% of the people who have alcohol and drug problems are in the treatment system, and if we want to do things to try to get increased penetration, then it will be a very costly venture unless we de-emphasize residential treatment. It simply is not economical to provide that kind of treatment nor does it seem to be necessary for most people.

QUESTIONS AND DISCUSSION

Angela Stelmakowich - Canadian Occupational Health and Safety News

You said we should look at individual programs to meet individual needs. If the attitude of the client and the therapist are the two most important points, why wouldn't it be most effective to use a general program to save costs?

Garth Martin

I didn't mean by individualizing that you only have one therapist working with one client at a time. I meant that you need to individualize the treatment which you provide within a general program or in a group. I was trying to get away from "canned packages"; it doesn't mean that you can't operate certain programs in general ways which allow for individual needs to be met.

Angela Stelmakowich

You also said that relapse shouldn't be seen as a failure. Is it a tendency for people after they have gone through a program and relapse that there is still some improvement? I can't see why it wouldn't be a failure if there were no improvement.

Garth Martin

Relapses take many different forms and relapse itself is only an episode. One needs to look at a broader context of judging the outcome of treatment. One US study of treatment of alcohol abusers studied people from a large number of treatment programs and involved a very large sample. This study found that at any point during follow-up there were the kinds of outcome results I described--the rule of a third. But if you took the sample at the end of four years and asked how many people had been abstinent for four years, the result was 7%. So obviously 93% of the people relapsed in one way or another over those four years. But if you said treatment success rate was 7%, you would be doing a disservice to a lot of people who made a lot of improvements along the way.

Angela Stelmakowich

So there is some measurable improvement even though they might actually go back to it three years down the road?

Garth Martin

Yes. I think if a person relapses and continues to use the substance the same way as before treatment, that obviously has not been a success. But one needs to look at what has happened over the interval and compare that to what was going on before.

LEGAL ASPECTS OF EAPs

Lillian Vine

Our next speaker, Robert Solomon, is a professor in the Faculty of Law at the University of Western Ontario. He has been involved in research and teaching on substance abuse law and policy for twenty years. He has published widely on various aspects of the drug trade, the development of Canadian drug laws, and the drinking and driving legislation. He has served as a consultant to Health and Welfare Canada, Concerns Canada, the Ontario Liquor Licence board, the Addiction Research Foundation of Ontario, and the Canadian Centre on Substance Abuse.

In recent years, he has concentrated on developing programs to assist segments of Canadian society in addressing substance abuse problems. One of his major areas of concern has been research on civil liability for the conduct of the intoxicated. He has helped develop programs in this area for the Ontario Liquor Licence Board, Health and Welfare Canada, the Addiction Research Foundation and the Council of Ontario Universities. He has travelled widely in the past five years, giving seminars to members of the hospitality and insurance industries, and to students and administrators at Canadian colleges and universities.

Robert Solomon

Before discussing some of the legal issues involved in EAPs, I want to address several points that were raised in this morning's presentations.

First, we in Canada must not put too much emphasis on the American experience. We do not have a great deal of positive things to learn from the United States in terms of drug testing, the nature of Canada's drug problems, or the range of reasonable solutions. Fortunately, our drug problems are not as severe as those in the United States. Moreover, I have always viewed Canada as being a much more humane society than the United States. The broad range of experiences in the United States reminds me of the Bible. Namely that you can find support for any possible position by selective reference to American data. We should focus on Canadian drug problems, Canadian law, and Canadian solutions.

Second, I would also suggest that the solution to social problems, such as substance abuse, will not lie in the mouth of lawyers. Unfortunately, there has been far too much emphasis on the criminal law and other legal responses, and not nearly enough on treatment and education.

In the area of employee drug testing, we have tended to get stuck on the issue of "Is it legal?", without asking whether it makes sense. While we must ask "Is employee drug-testing legal?", we must also consider what it will accomplish and what we give up in relation to what we get in return. Lawyers are helpful in answering only the first question. There are many things that are lawful but not helpful, and we should never confuse those issues.

Third, I have been very concerned about the prevalence of what I call the "Miami Vice" view of drugs in Canada. That is, our society's tendency to overemphasize illicit drugs, and downplay the harm caused by alcohol, tobacco and various pharmaceuticals. While the "Miami Vice" view of drugs may make for dazzling headlines and great TV, it warps public policy. Perhaps more importantly, it detracts public attention away from the greater risks posed by alcohol and tobacco.

This problem is best illustrated by the Benjie Hayward case. He was a 14-year-old boy, who went to a rock concert and took LSD, and subsequently drowned in Lake Ontario. That was a horrible, terrible tragedy, and my comments should not be seen as minimizing the horror of that event. After his death, the government set up a one-person task force to investigate the drug problem. There were banner headlines and a well-publicized coroner's inquest. There were statements of outrage from various politicians. The Benjie Hayward case made front page news across this country for six months. During that same six-month period, over 90 young people between the ages of 16 and 24 were killed in alcohol-related car accidents in the province of Ontario alone. Yet, there was not one word in the media, nothing. No task force, no statements of outrage, and no calls for action. It was almost as if those 90 deaths did not count.

It is essential that we accurately identify the real risks of harm and not get drawn into the American "war on drugs" mentality. It is quite clear that the number one drug risk in terms of safety is alcohol and that the number one risk in terms of health is tobacco.

Fourth, I am concerned that our efforts in EAPs not blur the boundary between social control and treatment. Social control typically involves the state and the individual in adversarial positions. The individual is granted certain civil liberties and various legal and procedural protections. I do not want to see counsellors, therapists and others in the helping professions drawn into an adversarial position with their patients and clients. If such professionals are co-opted into positions of authority, it will undermine all of our treatment efforts.

I now want to turn to some of the legal issues that arise in EAPs. There has been a great deal of discussion about the legality of drug testing and far less attention to the law governing EAPs.

This is ironic because the legal issues posed by EAPs can be more complex than those in drug testing.

Many of the legal problems associated with EAPs stem from confusion about the meaning of two legal terms -- confidentiality and privilege. The legal profession and the courts generally define confidentiality in terms of an individual's obligation not to willingly disclose information that he or she has received in confidence. An obligation of confidentiality may be imposed by statute, voluntarily undertaken, or it may arise under the terms of a contract. Increasingly, the Canadian courts are assuming that anyone who holds him/herself out as being a counsellor or therapist is subject to an obligation of confidentiality.

Members of the public and people who use EAPs, may view confidentiality as meaning that the therapist will never tell anyone or that "their lips are sealed". That is not what confidentiality means.

For legal purposes, the concept of privilege refers to those relationships in which the law recognizes the right of an individual not to disclose confidential information, even in the face of a search warrant or a subpoena. Virtually all of the information an EAP counsellor receives is confidential. However, very little, if any, will be privileged. The only relationship that the courts automatically recognize as being privileged is that between a lawyer and his or her client in the course of their professional relationship. A counsellor can ask the court to privilege the information, but it is the judge who decides whether or not to do so. Generally, judges give greater weight to the importance of having the information available in the legal proceedings than to concerns about confidentiality.

I will now discuss some of the practical implications of the two concepts. I go to your EAP, because you advertise that all the information is held in "strictest confidence". What that means to me is that you will never disclose any of our discussions. Unfortunately, that may not be a choice that you can lawfully make. If a police officer comes with a search warrant for your records, you must release that information. Your failure to do so would constitute a criminal offence. Although I may feel betrayed, from a strict legal point of view you have not violated your confidentiality obligation because you did not <u>willingly</u> surrender the information. Similarly, if I mention to my doctor that I have been having blackouts, the doctor has a legal obligation under the Highway Traffic Act to notify the Registrar of Motor Vehicles. It imposes a mandatory reporting obligation on physicians and optometrists to report anyone above the age of 16 who may have a physical condition that may make driving hazardous. Perhaps the broadest mandatory reporting obligations arise in relation to child abuse. If I come to your EAP and disclose that I am worried about hurting one of my children when drunk, you may have no choice but to notify the Children's Aid Society despite any promises of confidentiality you made.

It is important that those to whom a promise of confidentiality is made in an EAP understand what it means. We want to avoid the numerous double-bind situations that EAP counsellors can get themselves into. Should I betray the worker's trust and destroy the EAP's credibility, or do I remain silent and violate the law? We should not create in the minds of employees an impression about how we will handle information that conflicts with our legal obligations.

As an EAP worker, are you under a legal obligation to report a crime? In terms of the criminal law, at least, the answer, with one exception, is no. Under the <u>Criminal Code</u>, it is an offence not to report cases of attempted high treason. I have no idea what high treason involves, other than perhaps attempting to shoot the monarch or the Governor-General. You are not under legal

obligation to report any other crimes. Nevertheless, you may incur civil liability for failing to warn potential victims of future crimes in certain limited circumstances. But this issue of civil liability for failing to warn is best left for a future talk.

EAPs pose complicated legal issues. However, once you are aware of the nature of the basic legal concepts, it is relatively easy to avoid the legal pitfalls. The key is designing EAPs and consent forms to address the potential areas of misunderstanding.

I would like to end on an important theme. We may never all agree on who is to blame for substance abuse in the workplace. Some people blame the drugs, others blame the workers and some blame the workplace. It is far more productive and easier to agree on how to make progress than it is to agree on who to blame. A point that is frequently lost sight of is that the goal is not perfection. Rather, the goal is "less worse or more better." Anything that companies and workers do to decrease the harm posed by alcohol and drugs is a step in the right direction and merits the support of all parties.

QUESTIONS AND DISCUSSION

Eugene Oscapella - Privacy Commissioner of Canada

What is the position of the company physician? Obviously s/he has professional obligations of confidentiality; s/he is also an employee of the company. The company physician who receives information in confidence from an employee is also an employee. Does the employer have any rights to get that information?

Robert Solomon

Absolutely not. Health care professionals are governed by the Health Disciplines Act which makes the wrongful disclosure of patient information a grounds for professional misconduct. In my view, no private agreement between a company and a company doctor can override the obligations that a health care professional has to his/her patients.

Unfortunately, this may not be the understanding of the company and the doctor. Once we can identify this problem and everyone has the same understanding of their legal obligations, considerable progress can be made.

Angela Stelmakowich

The legal obligations you mentioned to report seem to me to refer to what you are doing in your social life after work. Does it apply to the workplace as well?

Robert Solomon

Absolutely. Those obligations under the Highway Traffic Act apply only to doctors and optometrists. Whether I learn that in my capacity as the company doctor or in my capacity as a private physician, it makes no difference. Similarly, we all have a legal obligation under the child abuse legislation to report cases of suspected child abuse. It is a very broad obligation and applies to everyone. The obligation imposed on health care professionals is even broader than that

imposed on the general population. You have no choice. If you fail to report in those circumstances, you are violating provincial law.

When you promise confidentiality in your documents, it is important to explain what that means so that you are not saying one thing to workers and doing another. That would undermine your program.

Angela Stelmakowich

If people know that the occupational health professional can be forced to give out information will they come forward voluntarily to use the program?

Robert Solomon

Right now, an occupational health professional has no choice. If you think the reporting obligation is getting in the way of an employee's best interests and is counterproductive, then you can lobby the government to change the law.

John Evans - Air Canada Medical Services

I am interested in the comment on occupational health physicians, being one myself. My understanding of confidentiality, which was explained to me by a company lawyer, is that if a patient is seen as part of a third party assessment (at the request of the company) results of that examination may be made available, although I don't know of any occupational health physician who does so. Generally the position is "fit," "unfit," or "fit with restrictions." If a patient sees a doctor voluntarily, then regardless of the physician's position as an employee of the company that is a confidential situation.

Robert Solomon

My response is that if a patient consents to the disclosure of the information, that is fine. Probably, what the lawyer was referring to were circumstances in which there was an implied consent for that information to be passed on. For example, if I come to a doctor with an application form that I want the doctor to complete, it is implied that the information will be passed on. Doctors should always ensure that an employee understands when they intend to send information to a third party and to get the employee's explicit consent.

Ian Arnold

We feel very strongly in both the section on occupational health for the Ontario Medical Association and in OMAC that the physician cannot pass any specific medical information to an employer other than whether an individual is fit, fit with restrictions, or unfit for work. We don't agree that the individual or company that employs you has the right to information of a medical nature.

REPORT FROM WORK GROUP A

Rapporteur - Alison Anderson

Our group came to no conclusions in defining the degree of the problem in the workplace and decided instead to define the resulting situations that we are actually responding to. We highlighted that corporations are concerned about safety for workers and co-workers as well as safety for the public. There is a concern about meeting legal requirements. We took into account economics, corporate reputation, consumer confidence in the product as well as the productivity issues. We looked at environmental safety and the general health and wellness of employees.

We then discussed the use and abuse of substances. We felt that "use" in a workplace setting could mean "abuse." There was no tolerance for any type of use in a workplace setting as opposed to that in the home. We agreed that we should look at the whole issue--alcohol and illicit and licit drugs. We identified many conditions that can lead to substance abuse--the corporate culture, design of the work, nature of the work and the work schedule, personal life, work situations, availability, peer pressure, work environment (heat, noise), supervisory practices, and lack of control.

We looked at reducing the harm, how to make it "less worse and more better." We felt that a supportive environment for treatment and recovery was critical. That information has to be available in the form of training and information sessions on the medical effects and repercussions of use. And that EAPs must address not just substance abuse but also workplace, lifestyle, and wellness issues. There has to be a well communicated policy; and integral to developing one must be a review of job design and practices, shift work issues, management practices. If these are things that lead to the cause, then they are important to the whole problem.

Who is responsible? Who has the control? Certainly we agreed that the individual had some responsibility, not blaming the victim, but rather, understanding that support might not always be there and the individual might be on his/her own. We agreed the workplace had a responsibility because it has the opportunity to address the problem. There is a responsibility on co-workers, managers, and peer support groups. We talked about the responsibility of governments in primarily an educational role and a support role rather than a regulatory role.

When we discussed alcohol and drug testing, we tried to understand first why testing would be done at all. Some reasons given are: to identify drug use, for cause, as a follow-up to a specific incident, random testing as a follow-up to treatment and as a pre-employment requirement. The purpose is to eliminate drug use in the workplace but we wondered if it worked and at what price. We agreed if there were to be testing it be part of a comprehensive policy that clearly sets out the repercussions. We noted that the test doesn't reveal the degree of impairment, and we talked about methods of measuring performance rather than the existence of a substance in the body. We were not sure testing would prove very useful.

We had concerns about how testing could lead to discriminatory situations and we weighed personal liberty against public safety. We talked about protecting privacy and confidentiality. Our group was inclined to support information interpreted by a medical review officer not going back to management and wanted a supportive EAP referral as a result. We wondered whether there were any circumstances at all in which testing would fit and identified pre-employment,

reasonable cause, and return-to-work contract. But we thought that the emphasis should be more on performance testing that was a part of a comprehensive policy with the other supports in place.

For treatment, we had concerns about the health care system and what is and is not funded. We had concerns about the need to go to the United States to receive treatment, either because it isn't funded here or because the waiting list is too long. We agreed with Garth's comments that outpatient treatment should be considered more often than residential treatment. We did feel though that the treatment was a relatively small part; that the support in recovery and re-integration in the workplace was extremely important. The peer support programs were seen as important and we felt there should be a contract between management and employee representatives.

Support is needed and counselling for the family and not just the individual should be considered. We discussed the role of the union counsellor and we were clearer on that role in the referral rather than in the follow-up and treatment. We did identify the importance of follow-up and agreed that was a good argument for treatment in the local environment. We discussed anonymous staff hot lines manned by volunteers who are recovered users and team-work design giving more opportunity for peer support in recovery and follow-up.

Eugene Oscapella

I want to raise one point about government responsibility. I have a certain degree of cynicism about the role of the political side of government in these activities, that they sometimes respond to the political necessities of the day rather than the realities of the situation and that agencies such as the Alberta Alcohol and Drug Abuse Commission and the Canadian Centre on Substance Abuse, because they are more detached from the political process, have a more critical role in education and development of policy than the political side of government does.

The other point I would like to make is about drug testing. There will be strong feelings about the value of drug testing. Certainly the office of the Privacy Commissioner of Canada, in response to proposed drug testing by the federal government, came out very strongly against it in most situations for many reasons--for the privacy implications of it and for the lack of usefulness of the information generated by the testing. For the record, we can note that there have been some strong objections to drug testing.

REPORT FROM WORK GROUP B

Rapporteur - Tammy Robertson

We had fairly lively discussion; this report follows the agenda.

Workshop #1 - Definition

Is there a problem in the workplace? We said there is and there isn't. We see no evidence of a huge problem but a certain percentage of the population in general is addicted, and we feel that it would be similar in the workplace--about 10%-15%. We felt that use in general is trending down in the general population and in the workplace; changing demographics and changing social norms might be responsible for that trend.

We think alcohol withdrawal in the workplace may be as dangerous as intoxication; someone who has an alcohol addiction and doesn't drink could be at as much risk as when s/he does. This relates to the issue of impairment. What is impairment? We need to look at this in a broader way.

Substance Abuse can affect a wide circle of people in the workplace and in the home. People who may not have an addiction problem themselves are often affected by a co-worker or by a family member who does. There is often a reluctance to report a colleague, and a co-worker or supervisor may become an enabler.

We thought it important to make a distinction between clinical dependency and occasional use. A good policy must address both those things. It needs to be clear if consumption of alcohol at lunch or at staff functions is OK.

We discussed gender issues. Prescription drug use is greater for women than for men, although that is changing. Women become addicted much faster than men and one drink will affect a woman faster than it will a man.

Alcohol, tobacco and prescription drugs are still the greatest problems. We sometimes feel that these drugs are "looked after," but that is not true.

EAPs are geared to men and most of the research has been focused on men and not women. Women often are not referred to the EAP as quickly as men are because they are often in lower level positions and their problems may go unreported and undetected.

We discussed the progression of the disease. Does it first start with stress in the workplace or does it start with the disease? Is it a primary illness or is it brought about by environmental factors and stress? We didn't come to any conclusion on that issue--there were different viewpoints. But there is an opportunity to address these issues in the workplace since people who have a problem may be more impacted by the threat of a job loss than by their family. Alcoholics will leave their family seven years before they give up their jobs. This is an opportunity for supervisors to intervene and help them get treatment. Support of the workplace is a powerful motivator for an employee to deal with the problem and get some help.

We discussed work culture and work factors--noise, heat, harassment--that could contribute to the development of a problem, and social systems that could be at fault. These are factors that need to be considered when developing strategies to prevent and treat substance abuse in the workplace.

Policies in the workplace may have to deal with multicultural factors--work, family and genetics and ethnic backgrounds affect risk of drug addiction. We discussed the correlation between tough economic times and consumption. During tough economic times there may be a tendency to turn to alcohol. We also noted that higher consumption levels were associated with higher levels of income.

In some situations, people in safety-sensitive positions have a special policy that is not applied evenly to all employees; that may seem unfair, but we agreed safety-sensitive jobs were special cases.

Finally we agreed the work environment is easier to change if you have worker participation in the development of policies and programs.

Workshop #2 - Prevention

Prevention of the problem is key. Prevention messages should be delivered in a variety of settings and in a variety of ways--lunchtime sessions, one-on-one programs, and educational sessions through the occupational health professionals. Wellness programs could help identify addiction problems sooner, as they address lifestyle, stress management and health in general. It is important that these programs don't come across as a management tool; they should be developed and ratified by both management and labour. Communication and the chance to make a contribution are essential to the success of such programs.

We also discussed peer-referral as a prevention program and not as a treatment program. There are many different models for peer referral programs and you have to decide which alternative you want to use. The focus should be on job performance and supervisor training programs and not in identifying substance abuse signs and symptoms. This led to the question, "How can you intervene if a worker's job performance is acceptable but s/he is obviously intoxicated?" It should be a part of the policy that workers cannot be impaired at work. At some point supervisors will have to make a judgment call based on clear signs of impairment or intoxication especially for work in a safety-sensitive position. Peer referral agents should not go to management with concerns but a peer committee could be in place which would refer to a confidential source. One of the models discussed was a program having three levels: the first level would be a co-worker expressing concern and outlining options; the second level would be someone in authority sending the worker for assessment; the third level would be an obvious problem and expert intervention would be involved. It is important to make distinctions between peer intervention, peer referral and peer reporting. Reporting involves mandatory identification of the impaired colleague.

Workshop #3 - Alcohol and Drug Testing

We discussed the purpose of testing. We felt testing was a response to a fear of injury in high risk situations; we also felt it could deter use on the job. It was suggested that as a deterrent it is only effective for a short period of time until people get used to the idea or figure out ways to get around the system. Testing doesn't measure impairment. What is an acceptable level of impairment? We accept exhaustion on the job but we don't accept drug or alcohol use. Is one more impairing than the other or are we simply passing moral judgments? There was considerable discussion around this issue.

Often the challenges to testing come from the wrong direction. Most focus on legality and accuracy. The big issue is what you do with what you find. The results should be used for rehabilitation and not for discipline. The reasons for testing are regulation, safety, productivity, absenteeism, deterrence, company reputation, and public trust. Testing often doesn't test alcohol. If you are going to do any testing at all it is absolutely necessary to test for alcohol, since it is the most commonly used drug in the workplace. If testing is done for alcohol it must be done via a breathalyzer, since urine tests don't correlate well with impairment. It is interesting to note that urine tests for marijuana also don't correlate well with impairment, but somehow that is perceived to be more acceptable.

We discussed performance screening where people would be tested through an interactive computer program to see if they were able to perform at a level needed to do their jobs. Many managers use testing as a way of reducing liability. Deterrence as a reason for testing might work on casual users, but would probably not be effective for those who were addicted. Drug testing has never been conclusively correlated with decrease in accidents.

In time, certain occupations may be identified with drug testing as part of the screening requirements. We need to talk about the alternatives to drug testing, such as supervisor training and prevention programs and demonstrate that they are cost-effective.

Organized labour has long pushed occupational health and safety measures instead of repressive measures. Some employees like regular health assessments in the workplace and feel that it is in their best interests, even though this runs counter to union policy.

Testing, if used, also needs to address management and management practices. The better solution could be safer technology in safety-sensitive areas. We accept a much higher risk for individuals than for technology.

Testing should be tied to management but kept separate from the occupational health professional. Company doctors shouldn't be caught in the middle of reporting test results. Contracting services out is an option, that would solve the problem of associating drug testing and often negatively perceived programs with departments within the organization that are meant to serve employees, such as Human Resources, EAP, Occupational Health and Safety and so on.

Post-accident testing may erroneously blame the use of a substance when that might not be the case--it might be the main factor or it might be a contributing factor or it might be a coincidence. But again the moral judgment can make it easy to detract from the major contributing factor and avoid having to deal with the real health risks in the workplace.

We feel testing is a final option. Education and awareness are required first to change the work culture.

Workshop #4 - Treatment

We see a lot of people going to the United States for treatment and it is costing at lot of money. We talked about the possibility of lobbying so that private therapists could be covered for substance abuse in a counselling program. In light of Garth Martin's presentation dealing with residential treatment, we think outpatient counselling may be a good option which we should advocate, rather than encourage people to go to the United States to get expensive treatment.

We discussed the importance of follow-up when someone gets back to work. Companies should focus on performance on the job rather than relying on random drug testing for relapse. There should be more emphasis on after-care and re-integration into the workplace rather than setting up self-fulfilling prophecies and using drug testing to catch someone doing something wrong.

Linda Wilcott

I would like to clarify one point dealing with peer referral programs. There are three models of peer programs: peer referral, peer intervention, and peer reporting. The peer referral is a CLC program in which a unionist will listen, refer and follow up with a co-worker. The peer intervention model is the one with three levels--a co-worker, intervention, and then disciplinary. The peer reporting was the other model.

QUESTIONS AND DISCUSSION

Linda Wilcott

Alison spoke about a team approach and I am not quite sure what that meant. If you mean it to be quality of worklife programs, the labour movement has strong objections to them. We are not opposed to working in cooperation with management through joint health and safety committees or joint EAP committees, but we have some difficulty with participatory management.

Alison Anderson

It came out in the issue of job design. Earlier we had talked about job design where you were only responsible for your own individual piece; then about the job design where you all worked as a group and as a group were responsible for the entire job. In discussions about peer support, we wondered whether a peer support group might be stronger where the job design was such that you were working in a team with responsibility for the entire job. I am not sure we resolved whether it would lead to more enabling or if it would lead to better success of the peer support systems.

Linda Wilcott

That is exactly what we would have difficulty with. Just for the record, the labour movement would have difficulty with that approach because it pits one worker against the other and is a union-busting tool, in our opinion.

Alison Anderson

Even when they don't go to management? The idea is they resolve the problem among themselves, they don't go to management. They are a peer support group without management.

Edward Sawka - Alberta Alcohol and Drug Abuse Commission

Yesterday, Dr Arnold and other speakers lamented the lack of good information on alcohol and drug use in the workplace. This is something that we felt in Alberta and AADAC was able to secure funding for a comprehensive research study of alcohol and drug use in the workplace. I would be happy to pass along the results. At the moment, the study is in the design stage. We are approaching the problem from a worker health and safety and performance perspective rather than the economic impacts of substance use in the workplace. We are interested in getting information on general prevalence of use, the impacts of that use and the perceived seriousness of it relative to other impacts that may affect performance and safety. We are also interested in finding out about the kinds of workplace programs that are in operation in Alberta and what people think of them. The study itself will involve qualitative and quantitative components, but the core of it will be a sample of about 2000 Alberta workers along with a sample of companies and unions. We expect the results to be available in the fall.

Eugene Oscapella

One thing that has been reinforced is the irrationality of the way society deals with drugs through the legal system. Here we are worried about many different types of drugs--over the counter drugs, alcohol, prescription drugs, and illicit drugs. Virtually everybody has agreed that we should be concerned about all of them and yet we have a rather irrational legal system which

categorizes these harmful substances in different ways that are not rational. I think in some ways that inhibits our ability to deal with them because we are dealing with entrenched attitudes based on the warped notion that one drug is worse than another because it happens to be illegal. Part of the long-term resolution of these issues is going to be getting a more rational legal system that will influence the way we think about some of these drugs.

CONCLUSION

Lillian Vine

To summarize: One thing that was said by the speakers and which I heard in the discussions in both groups is that we may be looking for a solution to a perceived United States problem. There is not a substance epidemic in the workplace in Canada, but it would be naive to deny that there is no substance abuse at all in our workplaces just as in our society.

There are blurred lines between home life and work life and dealing with the symptoms in the workplace looks after only a small portion of the problem.

You all implied that the issue should be safety and not moral judgment, which means dealing differently with different things in the legal system and elsewhere. You want a very clear distinction between chronic use and occasional use. You want to look at all that might be involved in the problem and that means not making a moral judgment--job culture, job design, peer pressure, the environment, schedules, lack of control.

Another important point you made was that support is vital. You were emphatic on how very important support was in the workplace and outside the workplace, within whatever systems exist--treatment, health care, EAPs, union counselling. Support is vital. And that is where our health care funding systems have been short-sighted in that whether in Canada or the US, residential facilities are covered, certain professionals are covered, but others, likely costing less, are not. You talked of the importance of family and peer-group support.

Drug testing was not highly regarded by either group. But you cautioned that if it were to be done for any reason, you had better be cautious about a lot of things.

You mentioned other factors in our perception of substance use, such as the gender issue, multicultural factors, and the economy. You spoke about control when you spoke about programs. There has to be involvement of employees in whatever program is developed so there can be a sense of ownership.

It has been a pleasure to work with the Canadian Centre on Substance Abuse on this workshop. The planning committee has been invaluable and the speakers were fantastic. But without your participation and the serious and very open discussions you engaged in, this program wouldn't exist. The past chairman of the CCOHS Council of Governors, Martin O'Connell, once welcomed the participants to a workshop by saying "Welcome to our love-in"--I always feel that way. From my point, it has been a marvelous experience; I hope you have enjoyed it. I hope to see you become one of our many "repeaters" at CCOHS workshops and seminars.

Mike DeGagné

I echo Lillian's sentiments on behalf of the Canadian Centre on Substance Abuse. This was a valuable experience for us. We are new and we haven't as yet begun to develop these types of workshops and symposia. The process that CCOHS has worked out is, I think, an excellent one; I have valued the exchange of information and the discussion has fleshed out my own opinions on the subject. Thanks again for coming. We have heard that one of the areas where we can help the most in the short term is in the process of gathering data and information. We are starting a collection of data on this subject through our electronic clearing house. What we need is information from your organizations. I will be putting you on our mailing list, but I also would like you to put me on your mailing lists to receive information from you. I thank you all for coming.

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